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I. VITAMIN C

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(1) Vitamins: A Survey of Present Knowledge. Page 167. Medical Research Council. Special Report 167. 1932. His Majesty's Stationery Office, London.

(2) Vitamins in Theory and Practice. Page 86. L. J. Harris. 1935. Macmillan, New York.
(3) 1935 J. Chem. Soc. 116, 1419.

(4) 1930 J. Home Econ. 25, 588.
(5) 1935 Amer. Jour. Pub. Health, 25, 1240.
(6) 1933 Ind. Eng. Chem. 25, 685.

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* Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
** Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
N. Y. State Jour. Med., Vol. 35, No. 11, 590
Arch. Otolaryngology, March 1936, Vol. 23, No. 3, 306-309

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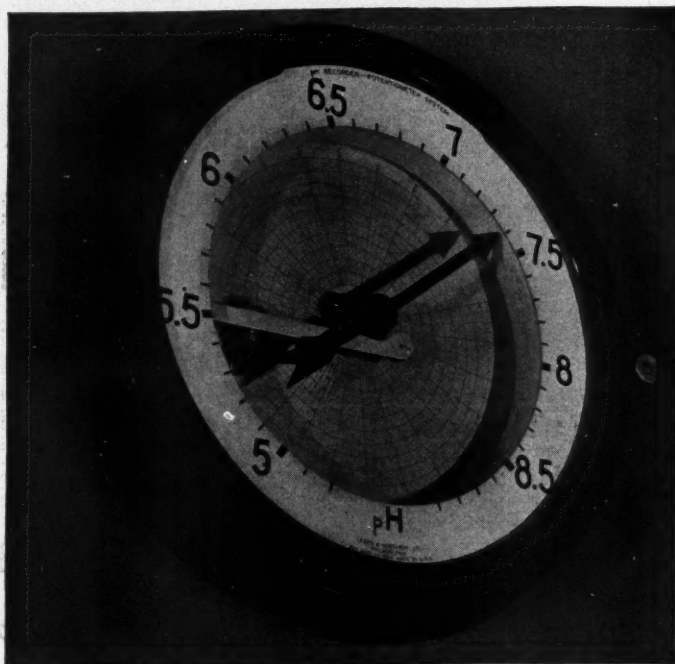
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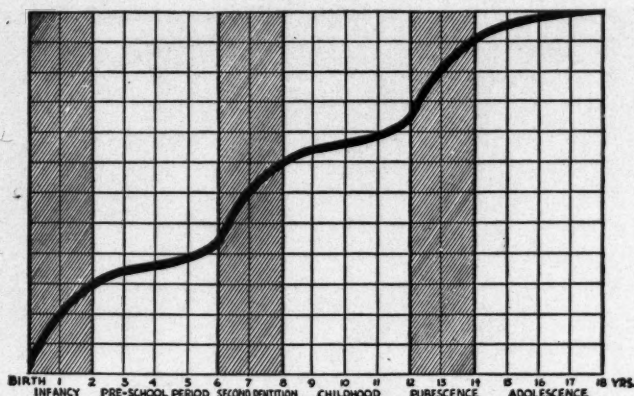
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FETAL MORTALITY IN RELATION TO TYPES OF DELIVERY*

NORRIS W. VAUX, M. D.**

Philadelphia, Pa.

In the practice of obstetrics, if we would analyze our end-results in relation to the fetal mortality without any specific thoughts in mind, we would find ourselves in a more or less hopeless and confused quandary, with nothing tangible to guide us in forming an opinion as to what method or procedure secures the best results for both the mother and her child.

I shall put before you the findings and complete analysis of the infant mortality occurring on my service at the Philadelphia Lying-In Hospital in five thousand, six hundred and fifty-five deliveries over a period of five years, mindful that I am in no way setting the results before you as commendatory, but rather the reverse; my interest being to bring to light what happens to the infant—ante-partum, intra-partum, and post-partum—in a large maternity hospital. Comparisons under like circumstances are within themselves odious and useless, as types of patients, locality and methods of treatment differ so in the minds and practice of other maternity hospitals and individuals throughout this country.

Constructive criticism is always of greatest benefit and very helpful to those who are ever striving to better the existing conditions. On the other hand, criticism is often freely given by those who have no idea of what their own work and results are yielding and the usual accompanying guesswork only befogs the issue.

In order to be more fully acquainted with the fetal mortality results in our department,

it was my pleasure to collect, analyze and review the work here presented. Let me here thank Dr. Tyson and his pediatric staff, and Miss Hanlon, the statistician, for their painstaking and thoroughly diligent work and their helpfulness in compiling and allowing me to present some of this material. There was no thought in my mind when this work was undertaken that it could be utilized in any way to prove any special or specific thing. Much to my surprise, after this material was collected, correlated and tabulated, I found that many valuable and instructive facts were brought to light. As I have previously stated, it is unfair to compare certain hospital results with another in the same locality or elsewhere, and it is not my purpose to show the good or the bad results of another institution, but the results here presented are simply given as a basis of comparison.

Neither is it my purpose to advocate any specific method of practice or method of delivery, but in no uncertain terms to set forth and compare that which in our hands has proved to be the better method of handling the labor, and the end-results of those cases coming under our guidance; to formulate and systematize the methods which we have found to give the best results in this fetal mortality survey. There is no doubt in my mind that some of those present will not agree with me on the recommendations that I might make, yet I have positively proved to myself that our, at times, so-called radical procedure of handling our cases is as efficient as the more conservative methods used by others, and until some quite definite and different results are brought forth to show their incorrectness, I shall continue to carry out that which, although radical, has given us the best results in the interest of the mother and her expectant child. After all, the baby plays a large

*Read before the Medical Society of Delaware, Wilmington, October 8, 1935.

**Clinical Professor of Obstetrics, Jefferson Medical College.

part in obstetrical work, and at times the importance of the safe conduct of the infant into the world is disregarded. We must, however, bear in mind that fetal mortality is of equal importance as maternal mortality. This fact must be emphasized if obstetrical practice is to hold its place and advance, as it rightly deserves, in the practice of medical art.

If I were given, therefore, to making a plea to my obstetrical confreres, that which I should emphasize would be a much more radical step in advance towards operative obstetrics, particularly in well run maternity hospitals, and to leave the decadent art of midwifery for the general practitioner to carry out in the homes. The specialty of operative obstetrics has come to stay, and it is our duty to emphasize this fact to trustees of medical schools, to faculties, and general medical practitioners alike, and insist upon at least an equal standing in the curriculum, on hours devoted to surgery, medicine, and obstetrics and gynecology, and that post-graduate instruction in specialties be compulsory in properly equipped and staffed institutions before individuals be permitted to wander ruthlessly into the field of operative procedures in obstetrics.

It has always been the purpose of the Philadelphia Lying-In and Maternity Department of the Pennsylvania Hospital to fulfill our professional obligation to private and ward cases alike, and it is generally accepted and practiced with few exceptions. Private patients are delivered operatively, so likewise are our ward cases. This then, accounts for the large number of operative deliveries, and I shall now take you more fully into detail of the statistical results relative to the baby, over this five-year period:

(Large series of graphs and statistical tables then shown).

The conclusions drawn from this review are:—

1. That a more full and detailed prenatal study of the causes of pre-maturity be undertaken and methods found to combat the high fetal mortality.

2. That the more radical procedure of operative interference and delivery in well equipped maternities, in trained hands, is justifiable.

3. That all breech cases be delivered operatively by decomposition and extraction as soon as the first stage of labor is completed, and that all large breech babies with questionable disproportion in primiparae be submitted to Caesarean section.

4. That the fetal mortality be looked upon with equal importance as the maternal mortality.

5. That only through more special training and more intensive studies of pelvic disproportion and the toxemias of pregnancy can we hope to bring about more radical methods of dealing with the abnormalities of childbirth. That in the end-results the more radical procedures in competent hands and in properly staffed maternity hospitals have given a safer and better method for handling the complications of obstetric abnormalities.

6. That maternity cases, especially the toxemias and premature labors, should be given a very much greater share of study, in particular the placental histology and chemistry, and that the endocrine system be more fully investigated during the course of gestation.

7. That lastly, this review and analysis of fetal mortality in relation to methods of delivery offers a prospective mother a better chance for herself and baby in labor and delivery by intelligent operative intervention in lieu of the older and time-worn method of masterly inactivity.

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DISCUSSION

PRESIDENT NILES: You have heard this lengthy oration on obstetrical statistics. It has been very interesting indeed and rare in quality. I would like to hear some discussion.

DR. EARL BELL (Wilmington): Mr. President, I certainly want to thank Dr. Vaux for this wonderful paper. It brings a lot of subjects in maternity work to the fore which should be very valuable.

There is just one point that I wanted to mention. In reading these statistics it seemed that delivery was more safe in certain cases provided the membranes ruptured before labor started. When I went to college they taught me that the membranes should never rupture until after labor got started. I

wanted to ask Dr. Vaux if I had read these statistics correctly.

DR. PAUL R. SMITH (Wilmington): I enjoyed Dr. Vaux's paper very much, but I can't agree with him when he says that fetal mortality is as important as maternal mortality. These statistics came out a little faster than I could digest them.

DR. L. J. RIGNEY (Wilmington): Dr. Vaux, we enjoyed this paper very much, and anyone who has attempted to compile any statistics can appreciate that it has been a huge amount of work.

The impression it made upon me was that forceps delivery is very beneficial. Of course I am one of the younger men and I have been taught along those lines, that forceps delivery is beneficial in certain cases. In doing spinal punctures on a great many babies delivered both with forceps and spontaneously in this series of cases it was found there was bloody spinal fluid more frequently in spontaneous delivery cases.

I also was impressed by the fact that women delivered with episiotomy were in better shape than those who had not received episiotomy. If I understood correctly, it showed that women with second degree tears were in better shape than those with only first degree tears. I think that shows that episiotomy should be done in nearly all primiparae cases.

DR. EDWARD BOHAN (Wilmington): This certainly is a very splendid paper, and a very fine piece of work from the statistical viewpoint.

I would like to ask Dr. Vaux only one question. I do not see how you can judge fetal mortality without judging maternal mortality at the same time, and maternal morbidity. You may get a splendid fetal mortality and a poor maternal mortality. I would like Dr. Vaux to bring out a comparison which would show that the maternal mortality and morbidity has improved with the improvement in fetal mortality.

PRESIDENT NILES: Is there any other discussion of this paper? Dr. Vaux, will you close the discussion?

DR. VAUX: I would very much like to answer the query of Dr. Bell as far as the rupture of membranes is concerned before the

onset of labor and those that were not ruptured before the onset of labor. The fetal mortality was far better, there were less babies died, less intracranial injury, less abnormalities of babies where the membranes were ruptured before the onset of labor. Absolutely I was taught the same as he was, but we found it to be different.

The fetal mortality that Dr. Smith talked about, he didn't exactly see why we put fetal mortality on the same basis as maternal mortality. Doctor, I did it for the reason that I believe the teaching of the younger men, and from the standpoint of the individual, of course, to lose a mother is a very tragic thing, but nevertheless that mother considers her baby a very important part of her pregnancy, and we are making every effort that we can to try to get the fetal mortality lower and also to keep the maternal mortality down.

I would like to state in answer to Dr. Bohan's question, the fetal mortality is 2.4%; the maternal is 0.6%. Now, the corrected results with episiotomy are far superior for both baby and mother with episiotomy than without, as I tried to show you in the slides.

I am sorry, there is a great deal of statistical work in the paper and I know it is boring, and it is hardly possible to get this thing without a more direct study of the charts themselves.

I agree again with Dr. Bohan that the maternal mortality should go along with the maternal morbidity and the fetal mortality. It is too large a subject to bring all in one paper. We made a survey for a period of three years of maternal mortality and morbidity. I am sorry to say the morbidity runs around 19 per cent. The temperature is taken twice in every twenty-four hours while she is in the hospital. That is a rather high morbidity.

We do not find the morbidity in this series to be any greater in the operative deliveries than it was in the spontaneous: they were about equal. However, they were slightly in favor of the operative deliveries over the spontaneous.

I think that is all and I thank you very much for asking me to come down and address you.

DR. BELL: I thought I asked Dr. Vaux why. I don't suppose I did, but I meant to. If I read the statistics right, and he says I do, why does he have less deaths with rupture before than he does with rupture after the onset of labor, and if this is all true, why wouldn't it be advisable then to rupture the membranes a day or two prior to the expected date of primipara?

DR. VAUX: I can answer that question of Dr. Bell's only in this way—that we do it very much more frequently than we used to. I can't explain the reason why, but we never do it if it is a question of any disproportion or abnormality. We only do it when it is easy to do it without infecting the individual through the vaginal tract, and it is done easily with a puncture by forceps, not with cutting instruments, when the cervix is two fingers dilated; the membranes are ruptured and the patient kept non-ambulatory and in bed. Our fetal mortality is less in that division, but I can't tell you why.

CERTAIN PHASES OF ACUTE OTITIS MEDIA*

CHARLES P. WHITE, M. D.**
Wilmington, Del.

It is my desire to discuss with you today the matter of acute otitis media, acute middle ear disease, a subject which is not new, I am willing to admit, but it has been selected for the reason that almost every doctor comes in contact with acute otitis media sooner or later, and sometimes it is not so easy to handle. You all know the etiology, symptomatology, prognosis and course of acute otitis media, and its liability at times to terminate in mastoiditis, and it is not my idea to consider these in detail, but rather to take up certain phases or angles of this disease.

The first of these is the matter of paracentesis, and the question I shall put before you is: Shall we open every ear drum in acute otitis media? Where we have an ear drum that is swollen and reddened, with pain and temperature, and this pain and temperature cannot be referred to anything else, I should say these cases justify opening. And this

brings up the query: what are the dangers of paracentesis? Referring to the books, you will find described that condition where there is no floor to the middle ear cavity, or where there is a partially absent floor due to a dehiscence in the bone, and through this absent or partially absent floor there may be a protrusion of the jugular bulb into the middle ear cavity, and it is possible that an unlucky operator, about to do a paracentesis, might plunge his knife into the bulb, and have a severe or serious hemorrhage. I have never had such an experience, and I hope that none of my colleagues have, for it is possible that while such a hemorrhage might be controlled by packing the ear canal, it is just as likely that it might not be easily controlled; and, anyhow, I would rather discuss it in the abstract here than have to do with it in reality. If any of my colleagues listening have had such an experience, I would be glad to hear. The literature shows these cases to be quite rare.

And what are the other dangers of paracentesis? None, or very little, so far as I know, provided we do the operation carefully, yet I heard Dr. Kopetsky, a noted ear doctor of New York, say some years ago that he who did a paracentesis before the right time had arrived, rather did more harm than he did good. But the question I put before us was: Shall we open every ear drum in acute otitis media? Perhaps I can better explain what I have in mind by reciting one or two experiences.

Some time back I received a message over the phone to go to house so-and-so and open the ear drums of the patient I would find there. Arriving at the house I found that the patient was a little girl, about six years of age, convalescing from the measles, temperature about 100, with two somewhat swollen and reddened ear drums, but not uncomfortable. I made three visits to the house, at the expiration of which time the ears had cleared up and neither had to be opened. The reasons for not opening these ear drums, in spite of the message which sent me there originally, were the fact that the child was not uncomfortable and the redness seemed to indicate a receding otitis media.

*Read before the Medical Society of Delaware, Wilmington, October 8, 1935.

**Ophthalmoto-laryngologist, Delaware Hospital, Wilmington.

In another case I arrived at the house about ten p. m. and found there the father, mother and doctor, and examining the ears of the child, who was apparently very sick, my opinion was that it would not be wise to open the ear drums, and looking again, I maintained this position; whereupon the rest of the history was given me, which was, that the celebrated Philadelphia children's specialist who had seen the child that afternoon previously had stated that there was trouble with the ears, and he suggested that the ear drums be opened, and volunteered to do it himself, if agreeable. The Wilmington doctor disagreed with this, and my position in the case was to help settle this point. The child, as a matter of fact, had pneumonia, neither ear drum opened, and the child is alive and well. In this case, while the ear drums were swollen, the redness was not of such a character that the ear drums should have been opened, in my opinion.

In other words, paracentesis, as I see it, is usually attended only by the best results, but there are border-line cases, so to speak, where we can sometimes hesitate with advantage.

The ear drum having opened, either spontaneously or by paracentesis, we will have the condition of acute suppurative otitis media, and it is my custom to have the patient remain in bed for a few days, believing that the practice of sending the child too soon to school is prejudicial. My experience shows that it is best to have no plug whatsoever in the ear canal. No cotton plug, in my judgment, is to be thought of, and the gauze wick which it was my custom once to use has been discarded also, having experienced difficulty in having it applied to my satisfaction. The pus, in this condition of acute suppurative otitis media, like pus anywhere else, should be given the freest egress possible. Aspirin is given for what pain may still persist, for any stronger sedative might obscure the symptoms. Also, particularly if there is any question, it is wise to have a smear made to determine the micro-organism present.

As to the cleaning out of the ear canal, there are, as you know, differences of opinion, some claiming that the ear should always be dry cleaned, others claiming that syringing is as good as anything else, while others say to

put drugs into the ear canal in acute suppurative otitis media is merely to dilute the pus; but my own thought is that no one method suits all cases. Some can be dry cleaned with advantage, but for the generality of my cases gentle syringing with a boric solution gives as good results as any. Sometimes, nowadays, I use methaphen solution, having discarded argyrol and mercurochrome, because argyrol has a tendency to blacken the ear canal, while mercurochrome stains the canal red, both of which, to my mind, tend to confuse.

There comes a time when we wonder whether we are still dealing with suppurative otitis media, or whether we have mastoiditis confronting us, and in this transitional stage, if I may coin that term, it is my custom to give special attention to what is called the posterior superior angle. A bulging of this angle, I read in some book, was called an "almost pathognomonic sign," and this is about as I regard it. It is not to be thought that because there is no bulging in of the posterior superior angle that there is no mastoiditis, for this would be incorrect, for there may be an inflammation in the cells at the tip, in which event there might be no bulging; but, where there is such a bulging in a case of otitis media, it is, in my experience, worthy of our close attention.

At times, in spite of the best we can do, mastoiditis will come along. You all know the symptoms of mastoiditis, and it is not my idea to enter into any detailed consideration of it, but rather to discuss with you two angles, which are, first, the classical symptoms of mastoiditis, and, second, what kind of operation shall we do in acute mastoiditis.

The so-called classical symptoms of mastoiditis, as you know, are redness, swelling and tenderness behind the auricle, which often will somewhat protrude. These so-called classical symptoms are quite all right when they are present, but we are to remember that mastoiditis may come and the patient may go into the beyond and no classical symptoms ever put in an appearance. To wait for them, in other words, is sometimes to wait too long.

And, as to the kind of operation to be done in acute mastoiditis, the answer is: the most complete, simple mastoid operation possible. The cleaning out process should go as far to

the top as you can, avoiding, if possible, the opening of the brain cavity; but if the meninges do happen to protrude, this is no great matter, provided we are careful. We should go to the tip, remembering that the facial nerve is close by; we should go back to the lateral sinus, again remembering that sometimes it is not so far back; we should open the antrum, so as to have the best possible drainage; and we should thoroughly clean out the floor. We should clean out all the cells, whether bad or apparently good, because, after operation, if we do this, the chances are we will not be harassed by fluctuations of temperature; we will not have a tender mastoid, even after healing, sometimes necessitating another operation; and we will not have facial palsy, i. e., unless we actually injure the nerve. I have seen on two occasions facial palsy following mastoid operation, when there was no injury to the facial nerve, and if we should come in contact with facial palsy, following mastoid operation, we should, as soon as possible, after the operation and before the reactions of degeneration have set in, have the face electrically tested; and in all probability, it will be found that the nerve responds, in which event another operation is indicated to more thoroughly clean out the operative field, the trouble with the nerve being the edema or swelling caused by the cells left behind, and we will probably have the satisfaction of seeing the palsy disappear.

The last angle of acute otitis media to which we will refer is the matter of deafness. Deafness in the adult is often an economic problem and we can recall individuals whose usefulness to themselves and to the community in general would have been greater if their hearing would have been better. For many such individuals treatment is of no avail, and the world is awaiting better hearing devices. Otologists are agreed, I think, that a certain percentage of these deafnesses of later life are due to the ear infections of childhood and this furnishes another reason, a most important reason, why we should give cases of acute otitis media our most careful attention.

DISCUSSION

DR. W. O. LAMOTTE: (Wilmington): Dr. White asked me to discuss his paper. I hope nobody here will think or feel that I am dogmatic.

I am glad Dr. White has emphasized caution in opening drums and operating for mastoiditis. If we were discussing this subject in a remote country region where the physician has to do everything, I would say to him when in doubt incise the drum, and treat the nose and throat, and perhaps also if in doubt open the mastoid. Most cases of purulent otitis media can be cured without mastoid operation. The nose and throat and tubes have to be cared for before many of these cases will become dry. I could cite many instances. In fact ears following mastoidectomies may not become dry unless focal infection in Waldeyer's ring have been removed. I have seen mastoid cases continue to discharge pus through the mastoid incision until small, embedded, infected tonsils were removed, when these openings promptly healed and the middle ears became dry. I venture the assertion that generally speaking when one does a great many mastoidectomies either patients have been neglected before operation or the operator has operated at times when it was not necessary. However, it is not always necessary for a frank case of mastoiditis to be present for an operation to be indicated.

If I have a case with a pneumococcal middle ear infection, the most treacherous organism in that locality, I am always concerned. There are, of course, cases that result seriously, and sometimes fatally, no matter in whose hands the patient has been even from the very beginning. It is better, as a rule, to wait until the infection has been localized and the body has had a chance to form some immunity before operating, as complications are less liable to result and the post-operative course will most likely be shortened, healing sometimes in as short a time as two weeks. I think I could prove that if necessary and time permitted.

I am just going to mention a few conditions about which some of us can easily be mistaken, even otologists sometimes, who have had considerable experience.

I think I have seen perifolliculitis or purulent infection in the external auditory canal which resembles very much acute mastoiditis. I have seen what was probably allergy with swollen canal, red drum, auricular displacement, and postauricular edema, diagnosed and insisted upon as mastoiditis and operation advised by the pediatrician but which disappeared in twenty-four hours. Do not put too much dependence in x-rays of the mastoid. My experience is that their reports mislead as often as they aid. That does not pertain alone to Delaware, either.

Last December a little girl, two years and eleven months old, was to have a mastoid operation in Connecticut the next day, indications being based entirely on x-ray report. She was brought to Wilmington that day. I inquired who the x-ray man was and they said he was an able man, that he had been assistant to Dr. Law in New York. We have Dr. Law's work here on x-ray of the mastoid. It is a pretty expensive book, and being in our library I hope somebody has made use of it. She was brought to Wilmington with no symptoms or signs of mastoiditis except the picture, and the picture looked like the mastoid was involved. The first picture that was taken here was blurred, but it was observed that the child moved slightly. Another picture was taken and the child was watched very carefully, and the mastoid cells were perfectly clear. In about five days the ear was dry and healed, and the child has not had any more trouble since. That was last December.

Dr. White is correct, too, in saying that when a mastoid operation has to be done it should be done thoroughly and the bony spicules and rough places cleaned off around the bony ridge, leaving a nice, clean surface.

Dr. White has given us sound advice, and his presentation has been very appropriate for a general gathering of physicians such as we have here. It seemed to me that it would be a good thing also to remind ourselves at this time of some of the things that delay or prevent good results.

DR. A. J. STRIKOL (Wilmington): I have had the pleasure of working with Dr. White for a number of years in the dispensaries, as

well as assisting him in private work, and I have always found Dr. White honest, conscientious and ethical with his patients as well as with his fellow practitioner. He does not have anything to sell, any new stunts or new treatments, but common horse sense. I have always found him to have that, and when I have been in trouble I have asked Dr. White to help or to give his valuable assistance.

As far as the ear conditions are concerned, I agree with most of them. Of course there is a little difference of opinion when it comes to paracentesis, as Dr. White has said. He states that almost every doctor comes in contact with acute middle ear conditions. No doubt. In fact, many of them are not diagnosed because the doctor fails to look at it. It is very easily diagnosed, and after the diagnosis is made the question is, should a paracentesis be made or not?

I can answer best by quoting Dr. Paige, of the Manhattan Eye, Ear, Nose and Throat Hospital, and he states that there are three times as many mastoids performed after spontaneous rupture than after paracentesis. Three times as many. There is no question but that when you have an abscess, no matter where it is, you must establish drainage, and the sooner you establish drainage the sooner the patient will benefit from it.

As far as the after-treatment, or the classical signs of mastoiditis, and so forth, are concerned, nothing our textbooks describe will help you out. It is a clinical experience. It is a thing that is absolutely necessary.

As for cleaning out the mastoid, the cleaner the better, as Dr. White said. We must clean it. We must not be satisfied, especially the men who profess to specialize in ear and mastoid surgery, must not be satisfied with only removing the cortex and curetting a few cells and letting it go at that. It certainly is not just to the patient or the doctor who has referred the patient to us. The cleaner the better, and you will preserve the hearing if you do that.

DR. I. W. MAYERBERG (Dover): Mr. President and Gentlemen: Dr. White has brought out some very important points today from a practical standpoint. We always know when we hear Dr. White that we are going to hear

something worth while. He has proven that again today.

I have dropped from my vocabulary the term "paracentesis" in ear work because "paracentesis" implies a puncture. I much prefer the term "myringotomy," which Dr. White mentioned in his talk, because "myringotomy" means a clear incision of the tympanic membrane. By a free incision I mean one extending from the upper part of Shrapnell's membrane, following a curved route around the posterior walls, and ending at a point opposite the beginning of the incision.

The time to perform the myringotomy should be left to the judgment of the otologist. I say that, I think, advisedly, because some of you men call in otologists. Sometimes we have symptoms of pain, sometimes of temperature, and we think something should be done. I want to caution you not to stampede the otologist into opening a drum that possibly does not need to be opened. A redness of the drum does not mean that it has to be incised, temperature does not mean it, or pain. If there is the slightest possible bulging, that drum should be opened and opened freely, at once. Establish drainage, if possible through the normal route of drainage of the middle ear, through the Eustachian tube. Particular attention should be paid to the naso-pharynx. Solutions to shrink the tissues applied in the nose or the orifice of the Eustachian tube, if possible, with applicators, frequently causes drainage through the natural drainage canal.

It matters little what medication you are using after the incision. I think a solution containing camphor of menthyl in small quantities, and alcohol, and a little glycerin is as good as we can use. That particular solution is hygroscopic in nature. It abstracts moisture from the tissues and frequently is helpful in reducing inflammation of the drum. It also has the property of being pain-removing and is also slightly antiseptic.

Dr. White and I have a bit of difficulty about the after treatment of these cases after incision. I have seen some of his cases, have followed them on service, and have found that the ears have been syringed with a warm solution. In teaching my classes in the hospitals here, talking of otitis media, I give them one

rule to follow in my cases—never to syringe an acute ear. I qualify that by saying that is my opinion—never to do it unless you are specifically instructed to do so by the attending physician. That lets me out. I caution against that because in syringing you not only fail to remove all of the secretion but you actually force some of that infected material back into the middle ear and into the mastoid cells.

Mr. President, speaking of the classical symptoms of mastoiditis, my brother, who assists me in my clinical work at the Delaware Hospital, noted a case there last week, in the dispensary, with a typical classical picture of mastoiditis. The patient gave a history of having a discharge from the middle ear for three weeks and four days before he appeared at the clinic. The discharge had stopped and he developed a redness and swelling back of the ear. The ear was pushed forward and there was tenderness on what I thought was the mastoid foramen. We sent him to the ward. I did not see him at first and my brother made a tentative diagnosis of one of two things, either acute mastoiditis or furunculosis. The patient had a blood count around 10,000 white cells, and a temperature around 100, and that evening I found what I thought was a point of swelling on the superior posterior wall, as Dr. White mentioned, and apparent edema of the superior posterior wall. I, too, felt it was either a mastoiditis or a furunculosis. I said frankly I did not know which it was, but I knew the child had to be drained posteriorly. So I sent him to the operating room the next day and found a large furuncle going down to the periosteum. The bone was not involved. The x-ray showed it was not involved and I found no involvement although I did not remove any part of it.

So you cannot always go by classical symptoms. You have to use common horse sense in making these diagnoses.

DR. W. M. PIERSON (Wilmington): There is just one angle. Of course I agree with everything Dr. White has said, but there is one angle he did not touch on which I hoped he would.

Sometimes you see a case where the family probably has had somebody else that had

acute otitis media and the doctor ordered drops of some sort, and they think the first thing to do is to put medicine in the ear to relieve the ear. Probably by the time you see the ear mullen oil or some other medicine has been instilled in the ear canal. It is difficult to tell from the drum whether it is actually a case of otitis media, for the landmarks have been destroyed. There may not be any swelling above the drum.

If I have the opportunity to see the case before anybody else has seen it, I usually advise against putting anything in the ear, and I try to control the pain by aspirin. I feel that aspirin is the best thing for both children and adults. It is not going to relieve severe pain, but in most cases of otitis media in the early stage it does relieve the pain, and it will not destroy the symptoms as will medicine used in the canal. The next day you can tell actually what is going on, whereas in the case where a lot of medicine has been instilled, it is necessary to discontinue the drops and, because of the using of medicine, sometimes postpone doing an incision of the ear drum which might be necessary.

PRESIDENT NILES: Is there any further discussion of this paper? If not, I want to thank Dr. White for his most excellent paper. I am sure I voice the feeling of the Society in saying it was very well rendered indeed, and created a great deal of interest. Do you have anything to add, Dr. White?

DR. WHITE: Where the gentlemen have apparently disagreed with me they have not disagreed so much; we are all pretty much in accord. I thank those two or three who were so very nice, because I do not believe I measured up to those very nice words.

As to what Dr. Mayerberg says about the syringing, I have never seen any ill effects from *gentle* syringing. I laid stress, you will remember, that you had to suit the case; you had to temper the wind to suit the lamb, in other words. In some cases I positively cannot succeed in getting it wiped out to my satisfaction, and I know that Dr. Keeler, the man who just died, professor of otology, in his book said that he never saw any ill effects from gentle syringing.

As to what Dr. Pierson says, my paper was not inclusive of all the angles of acute otitis

media. I just picked out a few. But I entirely agree with him as to this home treatment of acute otitis media before the ear doctor is called in, which treatment consists of putting in some kind of drops. You go to the house and find the ear canal filled with this, and you don't know whether you have a discharge out of this ear or whether you have not. The first thing you have to do is to dry it out, and when you dry it out you probably get the smell of some drug, which shows you that somebody put something in there. I think it is better, as the doctor says, to give aspirin, keep them in bed, and wait, and not have the signs befogged by some drug.

THE "E's" OF NURSING*

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Wilmington, Del.

Young ladies, on such a momentous occasion as this, the commencement of your professional career, the usual and the expected thing is to have the speaker hand you a miscellaneous assortment of platitudinous remarks about the professional virtues you should espouse and the professional sins you should avoid—a whole lot of "Thou shalt's" and "Thou shalt not's." Well, there will be no new Ten Commandments here tonight, nor will there be any new prohibition act—let the shades of Moses and of Volstead rest in limbo, at least this once. But rather would I invite your attention to a brief discussion of the "E's" of your new calling; not the "e-a-s-e," for there is no such thing in the profession of nursing any more than there is in the profession of medicine. What I want to speak about are the capital "E's," the cardinal, fundamental "E's" of nursing—education, economics, ethics, esprit.

EDUCATION

First, education. Those of us who have been thinking about or are concerned with the education of the nurse have been worried for the past several years, for frankly the curriculum is not satisfactory. You have been taught something about anatomy and materia medica and chemistry, and a modicum of diagnosis and therapeutics and dietetics, and

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an introduction to physiology and bacteriology, to gynecology and psychology, and to a whole head-full of other ologies, the most of which will be relegated to the realm of more or less unpleasant memories, once you have passed your State Board examinations. A moment's reflection reveals that this present curriculum provides much too much education for the routine duties of bedside nursing, and much too little education to produce supervisors, instructresses and administrators. While it conforms fully to the present day standards, it is a straddle education you have received—too much for the routine things and not enough for the bigger things.

Years ago, Dr. William Mayo said that the girl who could not learn the minimum essentials of bedside care in six months would never make a nurse. Others have carried their protest against the present curriculum so far as to say that it is producing "half-baked doctorettes," with the implication that they were something more than nurses and yet something considerably less than doctors. This they justify with the statement that the curriculum, at even the best training schools, provides a three-year course, with 600 hours of instruction, superimposed upon a high school education; while the medical school provides a four-year course, with 4,000 hours of instruction, superimposed, in 40 of the 48 states, upon two years of college work. Here, I think, the comparison should end, for it is my firm conviction that no training school is attempting to manufacture "half-baked doctorettes" or "doctorettes" of any kind, but rather educated nurses.

Educational standards in nursing are rising, but educational standards in the community at large are also rising, though fortunately not as expensively, for the cost to the state of Delaware of a public school education is approximately \$93 per student per year, whereas the hospital that provides a home for the would-be nurse and an education does so at an average cost of \$916 per student per year (ten times as much), which means that for the 80,000 students enrolled the hospitals of the United States are spending \$75,000,000 a year on the nurses' training. This is only one item of many that I might mention that explains to this audience of lay-

men why modern hospitalization is so expensive to the patient, and in the nature of things I see no way by which certain of these items can be reduced and still give the patient the full benefits of modern medicine.

It is the function of the training schools to train nurses, and there is no person within hearing of my voice who would go back to the days when there were no nurses, as we know them today. No one here would tolerate conditions such as Florence Nightingale found at Scutari in 1854, when she blazed the trail that has led to the modern conception of nursing, and even then it took another 20 years for the United States to take up the movement, for the first training schools in this country were not established till about 1873.

In an effort to do something about the present curriculum, as far back as 1923 the Committee for the Study of Nursing Education recommended a course with 840 hours of instruction, but which, by eliminating certain non-nursing duties, actually reduced the time required to a probationary period of four months and a training of 24 months; in other words, a much shorter course, a much harder course, but a much better course. This is a fine recommendation, but will require a very considerable alteration in the internal management and financing of our hospitals. I think we will come to it, gradually. The ultimate, of course, would be a college of nursing, in which relatively little time would be spent on bedside instruction, but more time would be devoted to instruction in cost accounting and finance, in administration, in sociology, in teaching, and so on. In 1910 the University of Minnesota pioneered the way with just such a course, a five-year course, I believe, and grants at its completion the degree of Bachelor of Science in Nursing. Today a dozen such courses are open to those who are prepared to enter them.

It seems to me that the education of the nurse stands at the parting of the ways. We have got to have less expensive bedside care for the patient; so we are going to have more but cheaper nurses, or we are going to have fewer nurses, better trained and better paid, who will be called on for the more serious illnesses, leaving the bulk of the routine bedside care to "nurses' aides" or "nurses' as-

sistants," who will be given a separate course of six or eight months. If this program is adopted the State Nursing Act must be amended to provide for this new assistant class, and many of the 2,000 training schools must be discontinued. What the future will bring I do not presume to say, but it will be your task, young ladies, to help evolve the correct answer.

ECONOMICS

Dovetailing closely with and arising largely out of the nurse's education is the matter of the economics of nursing. Most of you young ladies took up nursing as a means of earning a livelihood, and so your practical bread-and-butter question is: what do I get out of it? Would that the answer could be painted in brighter colors than the facts permit, but here are the facts: (1) the profession of nursing is already overcrowded, with serious unemployment; (2) it is increasing faster than the increase in the general population. There are today 300,000 graduate nurses, or one nurse to every 416 persons, an increase since 1900 of 2,374 per cent, whereas the general population has increased only 62 per cent. Such overproduction (40 to 1) has produced this overcrowding, and what happens, then to the 25,000 nurses who graduate each year? 17,000 of them will become private duty nurses and earn an average of \$1,311 per year; 1,500 will become public health and industrial nurses and earn an average of \$1,720 per year; 6,500 will become institutional nurses in hospitals and clinics and earn an average of \$2,079 per year, including maintenance valued at \$500. Now, these averages cover many years and are made higher by the incomes of the older nurses: the newer graduates stand to earn only 60-75 per cent of these averages. As a matter of fact, recent records indicate that the average private duty nurse in Delaware can expect to work only 120 days, and earn \$600 a year.

Surely the nurse must love her work to stick to it for such paltry compensation—she must love it, but then love is a funny thing, anyhow, and so we find that at the end of three years one-quarter of the nurses have married, and at the end of eight years one-half of them have married. The others will ply their profession for a varying time, but on the average,

17 years after graduation they, too, will have retired. The competition of the annual crop of 25,000 younger trained nurses, plus that of 150,000 practical nurses, plus the economic plight of the public that buys her services, and the end of the road has come, in 17 years. The longest record that I know of is 51 years after graduation; there will always be these remarkable exceptions.

As I have already indicated, the great surplus is at the bottom, mostly in the private duty group; there is an actual shortage at the top. There is need even now for three times as many public health and industrial nurses as are employed today, and some day these jobs will be actually created and the money for them appropriated. It is with these public health, industrial and institutional nurses that increased education and experience means an increase in earnings, whereas the income of the private duty nurse, per day, is as large her first year out as it will be her twenty-first year. She is, however, a good collector and actually puts into her pocket 90-95 per cent of the fees booked, which make the 70-75 per cent collections of the medical man look sick enough to need a nurse, a very special one. Bearing in mind, then, the diminishing opportunities and the static income of the private duty nurse, the main lesson for you young ladies to learn from this array of facts and figures is just this: go away somewhere and take a post-graduate course in public health, industrial or institutional nursing, so that when your chance comes you will be ready. My private tip to you is: be prepared for the jobs that the other nurses cannot fill.

ETHICS

The third "E" is ethics. Many persons do not distinguish between ethics and etiquette, and seem to think they mean much the same thing. True, in any profession as distinct from a business, the two terms are inextricably interwoven, yet there is a very real and significant difference, for etiquette is defined as the art of conventional social behavior, while ethics is defined as the science of right conduct, the principles of morality. Character building begins in the home, and the basic conception of ethics, then, begins at mother's knee, and if that knee be firm enough and un-

derstanding enough no further textbook need be read.

Etiquette in nursing is a rigorous and precise thing that moves with the formality of an army, more exacting than Emily Post. By the same token, ethics in nursing implies a rigorous and formal adherence to the Golden Rule as laid down by the Great Physician. The nurses' code* is an unwritten, a traditional one, but nonetheless a very real and binding instrument. It is derived, naturally, from the medical code, which in turn springs from the Hippocratic oath and goes back to 400 years before Christ. Our code has been the subject of much misunderstanding and the object of some derision, yet we point with pride to the fact that the lawyers, the engineers, the advertising clubs, the Rotary, the Kiwanis, and many others have in recent times adopted something that the doctors have had for 2300 years—a code of ethics.

Rather than speak in generalities I prefer to speak of just two things that are required: secrecy and loyalty. In the course of her ministrations the nurse will of necessity see and hear many things that should never be divulged. Bodies are stripped and souls are bared, but never a word passes the lips of the ethical nurse. She is under the same obligation of secrecy, ethically and legally, that the physician is, and she who passes out a choice tidbit of scandal—on the QT of course—is no longer a nurse but merely a female who has gone through a training school and gotten a diploma. Be it said to the credit of the profession that legal actions against the nurses on this score are practically unheard of, yet this word of caution, young ladies, because of its supreme importance, is always in order.

The other thing I want to stress is loyalty. First, loyalty to the patient, which involves giving the best the nurse has in service, cheer and hope. Here there can be no cutting of corners, for the employer is entitled to an honest return for the monies paid. Second, loyalty to the physician, which means not only no criticism of him in his absence, but that wholehearted support which is so necessary to the maintenance of the patient's confidence. The

nurse who undermines the doctor's influence over his patient is guilty of the meanest kind of sabotage. Third, loyalty to your profession, which requires your friendly co-operation, your constructive criticism, part of your time, and some of your money. You face a changing world; you certainly face a changing profession, and so it is your bounden duty to give to that profession your most serious thought and your most earnest effort.

ESPRIT

The last "E" is the esprit of nursing, the spirit of the thing—a sense of union and solidarity, of common interests and joint responsibilities. In speaking of loyalty to the profession I have just mentioned two of the phases of this esprit, your proper criticism and co-operation. Now let us go a step further. In order to augment and nourish a proper esprit, join the local unit of the American Nurses' Association, and keep your membership up as long as you are in practice. Attend their meetings and take an active part in their deliberations. Above all, read the current literature of your profession: subscribe to at least one good magazine devoted to nursing and literally devour it—you must know what is going on and what are the latest advances. The surest way to become a has-been is to just stand still and let the rest of the world go by.

But there are other things to this esprit besides these demonstrable items. There are certain intangibles which motivate you—the realization that service to mankind is noble; the knowledge that you are doing a worth while thing; the inner consciousness of a life well lived. These are the things of which the spirit is made. Call it pride, call it ambition, call it idealism, call it what you will, it remains the force that changes a human being into a living soul. I urge you to cultivate it, for as Job (32:8) says: "there is a spirit in man: and the inspiration of the Almighty giveth them understanding."

CONCLUSION

Thus have I tried, in my feeble way, to indicate the cardinal points of the nurses' compass, and to help start you on what I devoutly hope will be a successful career. Fortune may never come to you, but you may attain fame—there is still room for another Florence

*The Florence Nightingale Pledge is the nearest approach to a written code, but has never been adopted as such by the American Nurses' Association.

Nightingale or an Edith Cavell or an Adelaide Nutting. I do wish heartily that you find happiness in your profession; and the real happiness comes not from chasing rainbows but from doing well each single day's task. Some tasks may seem futile, but to paraphrase Tennyson, it is:

"Yours not to reason why;
Yours but to do or die."

For what is nursing after all but a calling of hard work and scant reward, a life of service and sacrifice? Yes, service and sacrifice, yet you deliberately elected to enter it, and even though you know it has its heartaches, no amount of argument could wean you away from it. Ah, such determination is the rock upon which true greatness is built.

And now, in parting, let me offer you my sincere congratulations on your reaching, after three years of trials and tribulations, the enviable status of "graduate nurse." My congratulations. May your Alma Mater ever be proud of you, and may your future be all that you wish it to be. You have come to your commencement—your take-off, and so at every stage of your flight I wish you—"Happy Landings."

Thank you.

1022 Du Pont Building.

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Lord Kelvin's Anniversary

Lord Kelvin, who put science to work for humanity, was born 112 years ago, on June 26. No ceremonies are needed to commemorate his birth. Every cablegram that is sent, every mechanical refrigerator, every ship at sea—the age of electricity itself—are memorials to his greatness.

Science was a jumble of theories and mathematical formulas when Lord Kelvin was born in Belfast, Ireland, on June 26, 1824. He made it the servant of the common man. Theories alone might satisfy others; to Lord Kelvin they were totally worthless un-

less put to practical use. Throughout his career he did just that—put theories to practical use. And he encouraged his colleagues to do the same, declaring: "The life and soul of science is its practical application."

From the confused and contradictory theories of his predecessors about the movement of heat from one body to another, he formulated the laws of thermodynamics, making possible the development of the mechanical refrigerator. In recognition of this contribution one of the pioneers in electric refrigerator manufacture in the United States have named their product and organization in his honor; and scientists in the field of thermodynamics refer to absolute zero as zero degrees Kelvin, measuring all changes in temperature on the Kelvin scale.

In the field of electricity, too, Lord Kelvin's contributions were great. He early realized the potentialities of electricity, declaring in the face of constant ridicule that it would some day be among the leading sources of power. Alexander Graham Bell, inventor of the telephone, and Michael Faraday, the father of electricity, were close friends of Kelvin, and he constantly championed their work. He developed the first instruments for measuring electricity, the electrometers and electric current balances. His mansion at Glasgow was the first in Scotland to have electric lighting: Lord Kelvin always claimed it was the first in the world to be completely lighted by electricity.

There was nothing of the absent-minded professor about Lord Kelvin. He was an efficient, farsighted business man.

When the Atlantic Telegraph Company was formed to lay the first trans-Atlantic cable, Lord Kelvin was placed on the board of directors. The job proved too difficult for the engineers, so the brilliant English scientist showed them how it should be done.

The problem of safety at sea interested Lord Kelvin greatly. Compasses were not very accurate in those days. In the Navy during a battle, they were sometimes useless because of the concussion resulting from gunfire. On ships of steel and iron they were even more unreliable. So Lord Kelvin created a compass based on entirely new principles.

This compass, though modified somewhat, is still in use today.

Lord Kelvin's major interest, however, was in the study of heat—the science of thermodynamics. So great was his recognition of the importance of temperature, his biographers report, that he always carried a thermometer in his vest pocket. It enabled him to know, among other things, whether the room in which he sat was being kept at proper temperature for maximum efficiency.

He died on December 17, 1907 and was buried in Westminster Abbey. On his death, Sir Richard Glazebrook said: "In the century that has passed the progress of the world has been great; and toward that progress there were few men—may I say there was no man—who contributed more than Lord Kelvin."

The Volta Bureau

"We consulted several specialists, and all of them confirmed our fears, but none offered any solution of our problem." Thus the mother of a small deaf child wrote to the Volta Bureau. The sentence might be quoted verbatim from many letters written by parents of deaf or hard of hearing children, or by hard of hearing adults.

The knowledge that deafness is present and that it is incurable comes with the force of a major calamity. It is so crushing in its effect that something positive in the way of help must be offered immediately, if the individual is not to spend desperate years in a bewildered effort to adjust himself. The parents of a deaf child must be told that the child can be taught to speak and can be successfully educated, and that this education may be begun at home immediately, even if the child is not more than two years old. The parents of a child whose hearing is only slightly impaired must be given advice as to his adjustment. The hard of hearing adult must be told about lip reading, about hearing aids, about social efforts in his behalf.

The Volta Bureau was established for the purpose of furnishing all this information to all who ask for it. Its services are free. Alexander Graham Bell, the son of a hard of hearing mother, the husband of a deaf wife,

the lifelong friend of everyone handicapped by deafness, used the money received as a prize for inventing the telephone to found the Volta Bureau so that anyone confronting the problems of deafness might be assured of help. Advice is given as to schools and pre-school training, lip reading instruction, hearing aids, social contacts, psychological difficulties. While the Volta Bureau is not equipped to do employment service, it gives information in regard to the fields of activity that are open to the deaf and the hard of hearing.

The Volta Review, a magazine for parents and teachers of the deaf and for the hard of hearing, is on the reading table of many physicians. Pamphlets dealing with all phases of deafness, except medical problems, are available to all who ask for them. Lists of such pamphlets and sample copies of the magazine will gladly be sent free of charge. The Volta Bureau is located at 1537 35th St., N. W., Washington, D. C.

Children Decreasing

Readjustments in the medical field and in hospital organization in keeping with the United States population trend, is foreseen by John Glossinger, vice-president of the Kny-Scheerer Corporation.

Children are becoming fewer in the United States population, Mr. Glossinger said. Whereas, in 1920 children under five years of age comprised 10.9 per cent of the total population, by 1930 this age group formed only 9.3 per cent of the whole. This is all the more striking, he said, in that during the same decade the total population increased 16.1 per cent.

Also cited are these interesting Census Bureau figures about the sizes of American families. In 1930 there were in the United States 23,352,990 intact marriages, that is, marriages untouched by death or divorce. The largest category—almost a third of all—was the group of 7,447,328 families who are childless. One-child families numbered 5,254,863; families with two children, 4,246,459; those with three children, 2,650,730; and those with four or more children, 3,753,610. There were fewer children in city families than in rural families.

EDITORIAL

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VOL. VIII

JULY, 1936

No. 7

F. I. C. S.

Another of the already superabundant medical societies is in the pangs of birth. The baby has already been named—International College of Surgeons—and its nurses are getting ready to bedeck themselves with the awesome appendage of F. I. C. S. We have no assurance that there will be no transmutation into F. I. X., though for the sake of our personal friends among its nurses we hope there will be no such debacle.

What the American Medical Association thinks of this new baby is characteristically set forth by Dr. Fishbein in an editorial in the *Journal of the A. M. A.*, June 20, 1936, as follows. The italics are ours:

THE INTERNATIONAL COLLEGE OF SURGEONS—WHY?

Into the welter of scientific, pseudoscientific, medical and similar organizations which now appeal for the physician's patronage comes the

International College of Surgeons, promoted by none other than H. Lyons Hunt, who has already to his credit [sic] the Association of Medical Editors and Authors. The prospectus indicates that the purpose of the organization is to bring together in closer harmony the leaders of the various colleges of surgeons now in existence; yet there is not the slightest evidence that the colleges of surgeons in any other country have indicated their willingness to be brought together by this new organization. Among other objectives, the new "College" proposes to elevate the standards of surgery to a point at which international reciprocity may be realized; it is quite safe to say that international reciprocity in surgery must be a figment of the imagination for many generations to come. Apparently there will be a publicity department to keep the public informed as to what surgery can accomplish, prizes offered for research, a museum established in Geneva, a journal published and a building erected in Geneva, where the foreign promoter, A. Jentzer, resides. There are also to be annual meetings in the individual countries as well as a meeting every two years in Geneva. Finally, there will be three classes of members, notably members, fellows and masters, who will be entitled to place after their names the appropriate alphabetic insignia. The fellows are to be selected by election, appointment or examination. *Apparently the first comers are all being appointed*, but by whom and under what authority the prospectus sayeth not. Notwithstanding the obviously inflationary character of this prospectus and the complete lack of any well authenticated background for this proposed organization, a considerable number of American physicians have felt themselves highly honored by the receipt of the invitation and are already taking steps to extend the appendix to their names by the additional letters which they will purchase through this international college. There exists already an international surgical organization of standing and repute. No doubt an invitation to membership in this organization would be a considerable honor and well worthy of consideration by any competent surgeon. *An invitation to membership in the present promotion might be considered more of an insult to the intelligence of the recipient than a recognition of extraordinary qualifications.* One need not cast aspersions on the intelligence of the promoters. As psychologists they seem to have a fine insight into the weakness and folly of the average man, who likes to adorn himself in regalia and to adorn his cognomen with assorted alphabetic conglomerations.

The grim reaper has been actively engaged in mowing down the members of the local profession. Recently we recorded the deaths of Dr. Joseph P. Wales and of Dr. James Martin. This month we regret to report the death of Dr. Willard Springer and of Dr. Hugo L. Heitefuss. Mention should also be made of the death last week of the wife of Dr.

Junius A. Giles. To these bereaved families THE JOURNAL offers its sincerest condolences. The sudden exitus of young and old alike reminds us of the uncertainty of life and prompts the solemn query—who next?

The President of the American Medical Association, Dr. James Tate Mason, of Seattle, died on June 20, 1936, at the age of 54, of endocarditis, with multiple emboli. An ample obituary notice will be found in the *Journal of the A. M. A.*, June 27, 1936.

So far as we know, Dr. Mason set two records for the A. M. A. He was the first man to be elected President *in absentia*; he was the first President to die in office. By his death the profession loses a most capable leader. The duties of the Presidency will devolve upon the able shoulders of the Vice-President, Dr. Charles Gordon Heyd, of New York City.

WOMEN'S AUXILIARY

On May 26 the Delaware Branch of the Woman's Auxiliary held a luncheon meeting at the Wayside Inn at Smyrna. Mrs. Lawrence Jones, president, presided over the business meeting and introduced Dr. Morris, new Director of Maternity and Child Welfare, and Mrs. Trent, superintendent of Nursing Service, of the Delaware State Board of Health. Dr. Morris spoke most interestingly and convincingly on the work that he will attempt here and his talk was very well received.

Mrs. C. E. Wagner gave a very full report on the national convention held at Kansas City. In this connection it was reported that Mrs. Lawrence Jones was reappointed chairman of the National Archives Committee.

Mrs. Thomas Baker, chairman of *Hygeia*, announced six new subscribers. Also, that from the bridge tea held in April about \$35 was cleared. This money will be used to place 10 subscriptions to *Hygeia* in various institutions.

Mrs. Butler, chairman of sewing, reported 286 pieces completed and turned over to the Visiting Nurses' Association. The sewing meetings have been discontinued until fall.

It was announced that the next state meeting would be held at Rehoboth in October.

There were thirty-eight members of the Auxiliary present.

Low Basal Metabolic Rate and Use of Desiccated Thyroid

That the thyroid gland plays only a small part, if any, in the production of a low basal metabolic rate in conditions other than myxedema John M. Berkman, Rochester, Minn. (*Journal A. M. A.*, June 13, 1936), believes is suggested by the fact that, in the treatment of myxedematous patients with desiccated thyroid, very obvious conditions both physical and otherwise are completely eradicated by such treatment, whereas in the treatment of nonmyxedematous patients with low metabolic rates, desiccated thyroid is often required in much larger doses to maintain a normal basal metabolic rate, but it does not bring about any apparent physical change. Any classification of conditions associated with a low metabolic rate must take these facts into consideration, and a workable classification must ignore many highly important but unknown factors. The author gives the following classification, which he believes satisfactorily separates conditions associated with a low rate of metabolism: 1. Myxedema is a definite clinical entity associated with positive physical signs, including nonpitting edema, and a basal metabolic rate of —20 per cent or lower. 2. Cases of low basal metabolic rate without myxedema (a large group of cases that includes several subgroups) may be classified in accordance with various physiologic disturbances which are not of necessity associated with any physical characteristics. The low basal metabolic rate may be a familial characteristic and it is often associated with asthenia. A low basal metabolic rate without myxedema may be associated with menstrual disturbances, sterility or hypersecretory rhinitis. 3. In anorexia nervosa the lowered basal metabolic rate is associated with a combination of psychic disturbances and diminished intake of food. It may or may not affect individuals whose basal metabolic rate was previously within normal limits. 4. Hypopituitarism is a definite clinical entity associated with characteristic physical signs but without edema, regardless of the basal metabolic rate. There are two distinct indications for the use of desiccated thyroid in which its value has been definitely shown: (1) as a spe-

cific in the treatment of myxedema and (2) as a method of elevating a low basal metabolic rate to normal in the absence of myxedema for the purpose of improving the general condition of the patient. In general it would appear that, either through lack of familiarity with the use of desiccated thyroid or with the conditions under which its use is indicated, the full effect of this substance has in many instances not been obtained. The action of desiccated thyroid is slow, and therefore to some extent cumulative; also, following the ingestion of desiccated thyroid a considerable period elapses before the effect of the drug has entirely disappeared. For clinical purposes one should wait a month before attempting to determine an individual's basal metabolic rate following the use of desiccated thyroid. As a general rule one does not expect favorable results from elevation of the metabolic rate unless that rate is in the region of —16 per cent or lower and when such a rate is associated with definite symptoms, the most significant of which are fatigue and intolerance to cold. As a routine, in the absence of nephritis and cardio-vascular disease, an initial dose of 12 grains (0.8 Gm.) over a period of three or four days may be used. At the end of that time a metabolic determination is made.

OBITUARY

WILLARD SPRINGER, M. D.

Dr. Willard Springer, one of the oldest physicians in the state, died at his home in Wilmington on June 26, 1936, at the age of 84 years.

Dr. Springer was born August 28, 1851, in Mill Creek Hundred, the second son of Stephen and Elizabeth Love Springer. His mother was the only daughter of the Rev. Thomas Love, a Presbyterian minister.

After attending Newark Academy, Dr. Springer entered Lafayette College, graduating in 1871. After teaching school at Easton, he entered the University of Pennsylvania, graduating from the School of Medicine in 1874.

In January, 1881, Dr. Springer married Miss Etta F. Springer, this city, who survives. Four children also survive as follows: Dr. Harold L. Springer, physician; Willard

Springer, Jr., banker and civic leader; Mrs. H. C. Stout, of Williamsport, Pa., the former Helen Springer, and Mrs. Howard L. Baumgartner, nee Edith Springer, this city. There are seven grandchildren and one great-grandchild.

Dr. Springer was a member of Eureka Lodge, Delta Chapter, A. F. and A. M., the Delaware Consistory and the Delaware Shrine Club, and also the Sons of the American Revolution.

He served as president of the Medical Society of Delaware, and was the first president of the New Castle County Medical Society. He was also a member of the Medical Club and Obstetrical Society of Philadelphia, and for years was chief of the obstetrical division of the Delaware Hospital.

In 1877, Dr. Springer became a member of the Board of Trustees of the old New Castle County Almshouse holding the post 12 years.

Dr. Springer had been identified in banking and business circles for many years, having been president of the Industrial Trust Company and chairman of its board of directors. He was also active in the affairs of the Delaware Automobile Association.

He also was a vice-president and director of the Security Trust Company.

Previous to his illness Dr. Springer had been active in his practice, which extended over a period of 62 years. During his medical career he kept a record of the babies he brought into the world, reaching a total of 4,132, some of whom he had been physician to for two and three generations. The last was born March 27, this year.

Funeral services were held from his home on June 29, 1936. Rev. A. H. Kleffman, pastor of West Presbyterian Church, assisted by Rev. George Alison, of Bridgeport, Conn., formerly of West Church, officiated. Interment was in Lower Brandywine Cemetery.

HUGO L. HEITEFUSS, M. D.

Dr. Hugo L. Heitefuss, one of the most popular of the younger physicians of Wilmington, died suddenly of a heart attack at his home on June 29, 1936, at the age of 31 years.

Dr. Heitefuss was born in New York City on October 25, 1904. His preliminary educa-

tion was received in Holy Name Parochial School and St. Regis High School there. He studied for his A. B. degree at Fordham University, and received his degree in medicine from the Long Island Medical College in 1928.

He interned at Delaware Hospital from July 1, 1928 to July 1, 1929, and shortly afterward began medical practice in this city. He was a member of the New Castle County Medical Society.

Besides being chief of medicine at St. Francis Hospital, he was an associate of medicine at Delaware Hospital. He held membership in the Brandywine Business Men's Association, Wilmington Lodge of Elks, and Theta Kappa Psi fraternity of the Long Island Medical College.

He is survived by his wife, Mrs. Louise Howell Heitefuss; two children, Carol Louise, and Laurence Hugh; his mother, Mrs. A. F. Heitefuss, and a brother and sister, Frederick Heitefuss, of Newark, N. J., and Mrs. Marie Louise Walker, of Wilmington.

Dr. Heitefuss was particularly interested in the Big Brother movement and in Archmere Academy. He was an expert violinist, having studied under Walter Damrosch. Often he gave violin solos and obligatos in Catholic churches of the city. The funeral was held on July 2, 1936, with interment in Cathedral Cemetery.

BOOK REVIEWS

Exophthalmic Goitre and Its Medical Treatment. By Israel Bram, M. D., formerly Instructor in Clinical Medicine, Jefferson Medical College. Second edition. Pp. 456, with 79 illustrations. Cloth. Price, \$6.00. St. Louis: C. V. Mosby Company, 1936.

Dr. Bram's book is the outcome of twenty-five years of work in the goitre field, and the data derives from 16,000 cases, of which over 5,000 were cases of exophthalmic goitre. Much of the book, in fact over three-fourths of it, concerns the etiological theories, pathology, symptoms and diagnosis of goitre. The most valuable part begins with Chapter XV, where he describes his medical treatment. Briefly, it consists of removal of discoverable infectious foci; a program of rest and exercise; a properly outlined diet; the use of certain medicaments; and the application of

psychotherapy. That this method, in Bram's hands, has been singularly successful in making patients symptom-free is amply demonstrated by this volume. Whether other practitioners could approach his results is a matter of conjecture, for Bram considers many of his cases cured, whereas Hertzler regards the disease as a continuous process the normal termination of which is a cardiac death. However, both agree, and rightly so, that surgery alone is not a cure but only one step in the cure. Bram resorts to it in two per cent of his cases. One thing is definitely apparent—the practitioner who would emulate Bram's medical method must be thoroughly familiar with Bram's book. His consideration of the psychic factors is excellent. The book should be read by all physicians who treat Graves' disease.

Allergy of the Nose and Paranasal Sinuses. By Frank K. Hansel, M. D., Assistant Professor of Clinical Otolaryngology, Washington University. Pp. 820, with 58 illustrations. Cloth, Price, \$10.00. St. Louis: C. V. Mosby Company, 1936.

Of all the manifestations of allergy the most commonly encountered are in the upper respiratory tract. Up to a few years ago attention to the nose and paranasal sinuses was directed to the anatomy, the clinical manifestations, and the perfection of operative procedures. No distinction was made between infections, allergic conditions, or the combination of both, and unsatisfactory results were obtained from many operations. Hansel's massive work supplies the means for more knowledge of the physiology, biochemistry, pathology and immunology of the nose and sinuses, better diagnosis and more successful treatments. His book goes further: it is a general allergy. Among the 35 chapters there are chapters on Roentgenographic Examination of the Paranasal Sinuses, Other Manifestations of Allergy Associated with the Nasal Symptoms, Food Allergy, Gastrointestinal Allergy, Urticaria, Erythema Multiforme, Angioneurotic Edema and Eczema, Headaches, Bronchial Asthma, Allergy and Immunity in Ophthalmology, Hay Fever.

One would think that in presenting so many opinions the author tried to cover them all, and, judging by the number of references,

2,465 in all, he about accomplished it. There are apparently but few typographical errors, such as on page 353 "Table XXIV" should be "Table XXII," and on page 578 "papillomuscular bundle" should be "papillomacular bundle." He states on pages 642 and 643, "there is a great deal of difference of opinion as to the results obtained from the standpoint of the allergist and from the standpoint of the rhinologist. It is apparent that ionization, according to the opinion of the allergist, is very unsatisfactory, and that this type of treatment is far inferior to the allergic methods of management of the nasal manifestations of allergy." It depends upon who the rhinologist is. The index is complete. There is no index of authors, which would be handy at times.

Oslser said if one knew syphilis and tuberculosis he knew medicine. To these two should be added allergy, and Hansel's book should be useful to any physician active in any phase of medical practice.

Examination of the Patient and Symptomatic Diagnosis. By John Watts Murray, M. D. Second edition. Pp. 1219, with 274 illustrations. Cloth. Price, \$10.00. St. Louis: C. V. Mosby Company, 1936.

This is an unusual book, containing an unusually large amount of information directed principally to the use of the general practitioner. The author has attempted to simplify the practitioner's problem of early diagnosis and treatment by emphasis on accurate detailed history taking and careful analysis of symptoms and detailed methods of physical examination. The material is quite up to date and the short paragraph discussions of each disease, complication or laboratory procedure is clear, concise and presents the main issues without causing confusion by presentation of minor details about which there may be controversy.

One feels, however, that the book has attempted too much. It tries to combine the a b c's of early medical school history taking and physical diagnosis with a summary of the present accepted status of the pathology, pathological physiology and clinical findings of any given disease and at the same time give a detailed outline of the laboratory procedure

to be used in the working out of an accurate diagnosis. In addition the book is not well indexed. Emphasis is given the history and symptoms rather than the disease or syndrome itself. It is difficult in looking up a subject to locate it. The reviewer, for instance, spent considerable time in trying to discover an account of symptomatic diagnosis of fibroid disease of the uterus. It might be more useful if the many symptoms and the many items in the history taking which are outlined in this book were made sub-heads under the various diseases and syndromes. In the text as it stands are long numbered lists in regard to history or physical findings under the various sub-heads of nails, head, face, eyes, tongue, pulse, etc., all of which is quite difficult to correlate when one has a particular case in mind.

The excellent illustrations constitute perhaps the most valuable part of the book. They are quite appropriate, and particularly helpful in the section of disorders of internal secretions. The whole work has been done very thoroughly, and will be helpful to the general practitioner. Perhaps in a later edition some of the practical criticism above discussed will be corrected.

Synopsis of Diseases of the Heart and Arteries. By George R. Herrmann, M. D., Professor of Clinical Medicine, University of Texas. Pp. 344, with 91 illustrations. Cloth. Price, \$4.00. St. Louis: C. V. Mosby Company, 1936.

This is one of the best epitomes that has appeared recently on this subject. The history, clinical examination and cardiac x-ray are well covered. The chapter on electrocardiography is particularly well written. The chapter on cardio-vascular disease conforms to what one finds clinically. The chapter on nervous disorders with heart manifestations is also very well written and its diagrams well placed. The drawings and diagrams of the autonomic nervous system are excellent, but there is still room for additional work on blood pressures. His work with the Boullite oscilometer is quite interesting; it would be more interesting to know what were his findings with the popliteal, femoral, and tibial readings, especially the latter. The book, as a synopsis, can be heartily recommended.

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SUSSEX COUNTY MEDICAL SOCIETY—1936

Meets the First Thursday

A. C. SMOOT, President, Georgetown.
 G. E. JAMES, Vice-President, Selbyville.
 E. L. STAMBAUGH, Secretary-Treasurer, Lewes.

Delegates: G. Metzler, Jr., J. R. Elliott, G. M. Van Valkenburgh.

Alternates: Bruce Barnes, Howard Lecates, K. J. Hocker.

Censors: K. J. Hocker, U. W. Hocker, W. T. Jones.

Program Committee: Carlton Fooks, Floyd Hudson, G. V. Wood.

Nominating Committee: Carlton Fooks, W. T. Jones, J. R. Elliott.

Historian: R. C. Beebe.

DELAWARE STATE BOARD OF HEALTH—1936

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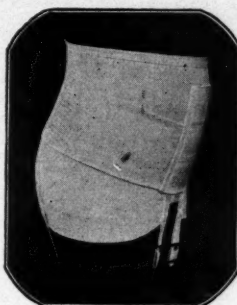
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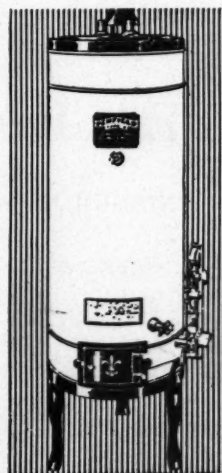
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